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Family of Origin Supervision in the Workplace : Impacts on Therapist and Team Functioning

Abstract

The Adolescent and Family Unit at Redbank House carried out a trial of Bowen's Family of Origin Coaching which has prompted us to comment on the usefulness of this approach as a component of clinical supervision. This paper will describe how this trial came about, the process adaptations required to make it possible and how some of the ethical dilemmas raised by this approach were addressed. Personal reflections from the team members will be shared and our observations in terms of impact of this form of supervision on clinical functioning, team cohesion and service provision will then be discussed. In essence, we aim to provide and anecdotal account of our experience and ask the question " Is supervision that focuses on the therapist's individual functioning as a product of their inter-generational patterns a valid use of resources in a clinical setting?"

Family of Origin Supervision in the Workplace: Impacts on Therapist and Team Functioning.

Murray Bowen first advocated the need for Family of Origin (FoO) supervision, or 'coaching' as he preferred, for clinicians in 1967 when he presented the outcomes of his own family work at a conference in Philadelphia. Exploration of this technique in the training of his Georgetown University students led him to later claim that it was precisely those students who had done best in their efforts with their own families who were also doing best in their clinical work (Bowen, 1978). At the time this sparked a lively debate about the ethical, practical and clinical dilemmas of FoO training versus approaches that focused more on skill acquisition, but despite this debate continuing to divide the field today, FoO has not benefited as equally as other training techniques from critical review. It certainly has not assumed the central position that Bowen argued for as a critical aspect of family therapy supervision.

A review of the literature suggests two major shifts in supervision practices over the past half century. The first concerned traditional supervision practices in which supervisors employed their theory of therapy to inform their choice of approach. These drew liberally on clinical theories and assumed that the teaching of clinical knowledge and skills that focused on the patient behaviour was sufficient training for interns (Bernard & Goodyear, 2004). The pivotal work of Ekstein and Wallerstein (1958) resulted in a major shift of attention to the psychology and behaviour of the supervisee, so that supervision became a predominantly experiential, rather than didactic, process in which the resistances, anxieties and learning problems of the supervisee were the primary focus (Frawley-O'Dea & Sarnat, 2001). The second major shift followed the increase in initiatives to establish evidence-based practices over the past 20 years (Falender & Shafrankse, 2004). This resulted in the emergence of theory orientated and empirically driven supervision models that aim to establish the process of supervision as a scientific practice that can be readily applicable to a variety of theoretical persuasions. Importantly, these approaches allow for the identification of the discrete components of supervision, from which models can be furnished, on which efficacy research can be conducted.

Family therapy supervision is usually placed within the traditional theory-based group of approaches given that they stem directly from the major schools of family therapy, namely, structural, strategic, experiential and Bowenian theories. However, consideration of the focus of each of these family therapy approaches suggests that Bowen Family Systems Therapy supervision is somewhat distinct, in that it places equal importance on the teaching of a comprehensive theoretical model and its associated clinical skills as it does on the personal growth of the supervisee who is encouraged to investigate their own family of origin (McDaniel, Weber & McKeever, 1983). Both these aspects then guide the supervision process. As such, while this paper does not aim to provide empirical data, it argues that the Bowen model is more reflective of the major shifts in supervisory practice over the last half century. In addition, based on our team's experience of this approach, we suggest that the exploration of a therapist's own family of origin is one of the model's critical components.

'Coaching' in Bowen's Therapy

Bowen coaching initially focuses on the teaching of his family systems theory (shortened to 'Bowen theory' from 1974) which focuses on patterns that develop in families in order to defuse anxiety. As summarised by Brown (1999), the theory describes how the degree of anxiety in any one family is determined by the current level of external stress and the family member's sensitivity towards particular recurring events that have been transmitted down the generations from their own family of origin. If family members do not have the capacity to think through current relationship dilemmas, but rather become reactive to a perceived threat that they attribute to these recurring events, a state of chronic anxiety is then set in motion that results in the emergence of symptoms in one or more family members.

Central to Bowen theory is the concept of differentiation of self which is described as the capacity of the individual to function autonomously by making self directed choices, while remaining emotionally connected to the intensity of a significant relationship system (Kerr and Bowen, 1988). In contrast fusion or lack of differentiation is where individual choices are set aside in the service of achieving harmony within a system. Fusion can present as either a sense of intense responsibility for another's reactions, or as emotionally distancing and cutting-off from the intense relationship (Kerr et al., 1988).

Also central to this theory is the process of triangling. Bowen described triangles as the smallest stable relationship unit, occurring when anxiety between two family members is relieved by involving a vulnerable third party who either takes sides or creates a detour for the anxiety. Triangling becomes problematic when the third party's involvement distracts the members of the original dyad from resolving their relationship tension.

Bowen theory links these key concepts in that the lower an individual's level of differentiation, the more likely they are to engage in emotional fusion or cut-off when under stress, and the greater their pull to reserve a comfortable emotional stability by forming a triangle. This triangle then excuses the original dyad from resolving their problem and symptoms arise as a result of the detoured anxiety.

While additional research is required to establish Bowen theory as an empirically supported model of practice, it is important to note that recent literature reviews (Charles, 2001; Miller, Anderson & Keala, 2004) have found studies that provide theoretical validity for a number of Bowen's concepts including chronic anxiety (eg, Haber, 1993), differentiation of self (eg, Hanson, 1998), triangulation (eg, Hanson, 1998) and fusion (eg, Wichstrom & Holte, 1995).

The second focus of Bowen coaching is on understanding the theory as it relates to the therapist's self with the goal of increasing the therapist's level of differentiation and their ability to de-triangle from client families. He stressed that the position a therapist plays in relation to the client family will be similar to the position that the therapist plays in their own family. So while family therapists tend to be mediators, communicators, bridging family members and overfunctioners in their families of origin (Titleman, 1987), making efforts toward modification of these dysfunctional aspects of one's functioning in one's own family is crucial in order not to project these personal biases and unresolved difficulties onto the client families. Bowen supervisees are therefore supported to notice these invitations to re-enact their particular family of origin roles early on in a counselling session, so as to make immediate changes in their behaviour that allows them to stay out of the client family's emotional process. This ability to maintain a position of differentiation within the clinical setting, that avoids invitations to be triangled between family members, is a priority for the developing Bowen family therapist.

In summary, as Carter and McGoldrick recall Bowen saying, 50% of the therapist's energy is directed into work itself and 50% is directed into staying out of the client's family process (McGoldrick and Carter, 2001, p.283).

Evidence for FoO coaching

A literature review of the keywords "family-of-origin", "training", "coaching" and/or "supervision" did not reveal any empirical studies that evaluated the outcomes of utilising FoO investigations as a training technique for the family therapist but did produce a number of discussion articles regarding FoO exploration in supervisory practice.

Advocates for the inclusion of FoO coaching stress that a trainee who has not worked on or is not willing to work on his or her FoO issues is "handicapped" (Kramer, 1989). Claims are echoed throughout the literature that "the more family systems therapists work on their own families, the more they are likely to be able to comprehend the (client) family as an emotional system" (Titleman, 1987, p.5) and deal with their own personal and interpersonal issues that might otherwise inhabit their emotional or psychological growth and development (Lawson & Gaushell, 1988).

The key concerns of authors who caution against including FoO work in supervision can be grouped into four key areas of contention (Young, Stuart, Rubenstein, Boyle, Schotten, McCormick, et al., 2003). First are narrative critiques (eg, White, 2001) that question why family of origin should be privileged over the trans-generational impacts of social, cultural and historical contexts. Second are the concerns initiated by Findlay (1997) that pertain to the ethical dilemmas and consumer rights of the trainee family therapist. Findlay was concerned about making FoO work compulsory for trainees (a stipulation for accredited family therapy and family therapy supervision courses in the UK), given that it can be "potentially unsettling, scary, confusing, painful or embarrassing" (Young et al., 2003), and so stressed the importance of explaining to potential trainees in "minute detail" what will be required of them during a family therapy course. In addition, he echoed the dilemma raised by Kane (1995) of the dual relationship that requires academic staff who have been exposed to sensitive FoO information to also provide objective feedback and academic evaluation of a trainee's work. The third is an issue of trainee maturity and experience, and the assertion that trainees benefit most from FoO training when they are over the age of 40 "simply because they have attained fuller knowledge of themselves, and thus have more points of connection with the personalities and patterns they discover in their families" (Mason, Gibney & Crago, 2002, p.49). Finally, and pertinent to our findings, is the reluctance in the past to integrate FoO coaching into family therapy practice (Flaskas & Perlesz, 1996; Mason et al., 2002), despite the fact that this view can be traced as far back as Jung's ancient idea of the 'wounded healer'. Reassuringly, the literature suggests a resurgence of interest in the coaching of the self of the trainee therapist, an interest shared by our clinical team and supported by its findings. While the following account of our FoO coaching trial does not aim to answer all those concerns raised in the literature, it is hoped that it will helpfully contribute towards keeping the debate about this "critical aspect of family training" (Bowen, 1978) alive.

Trial of FoO coaching at Redbank House

Context of the trial

The Adolescent and Family Unit (AFU) at Redbank House is a sub-acute voluntary unit offering tertiary level assessment and treatment to adolescents aged 12 - 18 years who have failed to progress in treatment in the community setting. While in the program the adolescent attends a twice-weekly skills training group, has individual therapy and their family attends a weekly family therapy appointment. The unit offers a day patient program during the school term and family admissions during the school holidays. Admission is considered for adolescents with psychiatric, emotional and behavioural disorders, family relational problems, social skills deficits and school refusal.

The program is staffed by a multidisciplinary team with psychiatry, clinical psychology, social work, nursing and educational professionals. The clinical team case manage the admissions and provide individual and family therapy to the adolescent and their family. At the time of the FoO coaching the clinical team consisted of two staff specialists in psychiatry (one of whom was the unit head), two psychiatry registrars, two clinical psychologists and two social workers.

Supervision on the unit

Regular clinical supervision has been an essential component of the AFU clinical team. Team members have regular individual supervision from within their own discipline. In addition, the clinical team comes together to engage in weekly group family therapy supervision with an external supervisor from the Family Systems Institute. This supervision comprises case presentations and discussions, the teaching of Bowen Family Systems Theory and 'live' supervision with families participating in the program. The unit adopted a predominately Bowen Systems Theory Model for supervision approximately six years ago. Prior to this, team supervision was not organised around a single model and drew on many different supervision approaches.

Bowen theory was selected by the team because of its strong focus on the therapist managing self. The complex nature of the cases that present to Redbank House, which often include a combination of underfunctioning parenting teams, a highly chronically anxious system, over-focus on the adolescent and low levels of differentiation in family members, are often a result of them failing to progress in the community which prompts an admission to Redbank House with hope of a 'cure'. These families present with a strong pull for the therapist to be directive rather then collaborative and family members give out frequent invitations for the therapist to triangulate or overfunction on their behalf. Drawing from the Bowen framework, our clinical experience repeatedly demonstrated how paying attention to managing self in session led to collaborative work between therapist and the client family that resulted in an increased capacity for the family members to self-reflect and so work towards increasing their level of functioning.

Another important outcome of selecting Bowen theory was that the approach allowed for discussion of not only clinical but also team and individual dilemmas and dynamics with a common language and from within a common framework. We hypothesised that if we were to apply the same approach to the workplace we would see the benefits we often saw in session replicated within the team. Specifically, the central premise of each team member focusing on managing themselves would be likely to increase objective and efficient functioning and prevent conflict, judgment of others and splitting within the team.

Why Family of Origin coaching?

At the start of 2007, during the annual planning and review of the coming year's supervision, the idea of experimenting with FoO coaching was floated. The team was experiencing a relatively stable and cohesive period of functioning with only a few staff changes. The team discussed the idea of FoO coaching as a way to expand everyone's understanding of the theory and to assist in keeping supervision fresh and engaging. The FoO coaching trial was also an effort to be more truthful to Bowen's theory, that is, it would provide a space to focus on Bowen's idea of the therapist needing to work on their own level of differentiation in order to be a more effective clinician. In addition, the team was intrigued about how such a trial would impact on the work setting given that this would be the first time FoO coaching had taken place at Redbank House. Overall the team was curious to see how having a structured format and space to reflect on their own family patterns would impact on clinical work, self -management and workplace functioning. It was hoped, as Papero (1990) supports, that if clinicians in a work place system are given the opportunity and space for self reflection there is likely to be less spill over to other unit/teams or disciplines, problems stay in one to one relationships which in turn reduces anxiety in the system and leads to better functioning individuals, teams and thus better client care.

Implementation dilemmas

Moving from conception to implementation raised a number of dilemmas for the team. Thoughtful consideration needed to be given to the make-up of the trial to make it a useful and appropriate experience for all team members. Indeed, a number of the ethical dilemmas and consumer rights issues raised by Findlay (1997) and his supporters arose during this process.

The question of who would participate was raised early on as the team had two psychiatry registrars who would only be with the team for six of the twelve months before rotating. Sessions needed to be spaced out to allow participants to research more about their families of origin, begin to experiment with developing person-to-person relationships, and observe the experience of differentiating self in family interactions. FoO was also only one component of supervision which still had to service current case presentations and live clinical work. It was decided with the help of the coach that only team members who were going to be present for the entire twelve-month process should participate. This time frame would provide participants with an adequate opportunity and space to reflect on family patterns and begin to implement the findings. When FoO was scheduled the non-participating registrars were provided with alternative supervision.

Another aspect in planning was that of voluntary participation. As the team were not family therapy students whose course requirements would make FoO compulsory or involve a dual grading role by the external coach it was agreed to make the trial truly voluntary. This was important as team members were going to be working together in an ongoing way and hence trust and respect of fellow participants was crucial. The coach was an experienced FoO coach from the Family Systems Institute who was able to provide the team with clear information about the process involved and potential hazards and pitfalls prior to consent to participate being given. Participants then decided for themselves if they were prepared to carry out the work this trial demanded. Only one eligible team member decided not to participate and joined the alternative supervision occurring concurrently. Six team members finally participated in the trial.

The potential split between participants and non-participants in the team was given careful considered to ensure that the process would not result in an insider-outsider situation developing where those participating would have a shared language or knowledge that would result in a sense of exclusion for those not participating. Being able to discuss this dilemma and keep consciously aware of it assisted the team from being split in this way.

The necessity of confidentiality was made overt. Participants could potentially discuss sensitive personal information about their family of origin, including patterns of managing chronic anxiety, t trans-generational themes and important nodal points. An opportunity to discuss how disclosed information would be managed and used was provided and clearly contracted.

The dilemma of having a unit head involved in the process had the potential to mirror the dilemma of the dual relationship raised by Kane (1995). This raised the dilemma of the unit head being privy to personal information and also being tasked with the role of assessing and appraising fellow participants in their annual workplace review. In addition, the unit head would be expected to divulge personal information that could potentially undermine her authority. Hence, all participants had the potential to feel vulnerable and there was potential for each to have at their future disposal sensitive information about colleagues. The processes involved in contracting the FoO coaching and the nature of the team, that is one that was already stable, coherent and well functioning, made this a non-issue in reality but nonetheless one that was essential to acknowledge so that participants could remain mindful of the purpose of the information being disclosed.

The issue raised by Mason and colleagues (Mason et al., 2002) that FoO is age-dependant also arose in preparing for our trial as team members varied from new graduates to highly experienced participants who varied significantly in terms of age and level of experience with Bowen theory. In reality the FoO process was reported to assist each person's understanding of the model by creating a lived experience of it. The age and experience level was not reported to be an issue because the processes involved required each individual in the group to focus on their own FoO experience according to where their learning and FoO exploration was up to. If anything, younger and less experienced participants reported a benefit from the presentations and thinking of more mature group members.

The final dilemma that arose was the issue of whether FoO coaching would enhance clinical work or whether it was essentially therapy to benefit the therapist as an individual. As we have discussed the FoO process requires participants to reflect on their own lives and family relationships in attempts to slowly lift differentiation. While focus on therapist functioning is not a new concept, meeting for supervision in the workplace does require the use of the organisations time and budget and hence there was a query as to whether this was a legitimate use of Redbank House's resources. As the team felt so strongly that this was an essential way in which the team could be truer to Bowen theory and had the belief that the positive effects resulting from this experience would impact on the individual therapist, clinical work and team functioning, it was unanimously agreed by the team that we should trial this process. The team was required to put forward a case for the legitimacy of the trial to the wider Redbank House system.

Implementation

The FoO coaching trial occurred over a 10-month period. It was decided that there would be eight 2-hour sessions scheduled during the 10 months. At the first session the coach presented her own FoO genogram and where her thinking was up to about her family patterns. She discussed the resulting efforts she has made and actions she has taken with her FoO to increase her level of differentiation. This first presentation established the format each FoO participant would follow in subsequent sessions. The goals and expectations of participants in

attending the group were also discussed so participants understood what would be required of them during the process.

During the trial each participant presented their family story to the group on two occasions. Each presentation was an hour long and involved the provision of information from the previous three generations. Presentations focused on what the participant was most curious about in relation to family patterns. Gaps in information and nodal points were also highlighted. The group could then make comments on or ask questions about patterns or themes that stood out for them. These questions were designed to assist reflection for the presenter. This experience was often challenging for participants. Reflecting on important nodal points, particularly in relation to experiences from childhood, understandably raised a range of strong feelings. Interestingly, it was noted by participants that sometimes events that were not expected to raise anxiety or were not considered relevant often had a major impact on them or their insight. As a result, trust and confidentiality were paramount to the success of participants in using these experiences to further their understanding of their reactivity in a safe and comfortable space.

What was also interesting to note was that most participants in the group identified themselves as overfunctioners in their FoO. This is not surprising given that they had all entered the mental health care field. What it did suggest however was that it would be helpful to generate in the participants an awareness of their potential sensitivity to invitations to overfunction, both in dealings with their client families as well as within the workplace.

As the FoO meetings progressed participants reported that while they were interested in fellow members presentations and their findings, they further utilised the process by applying the outcome of group discussions to their own FoO where similar themes or patterns had arisen. In other words, hearing others' stories and struggles provided rich material for their own reflections. This observation contributed to a lessening of the original anxiety the participants had expected as a result of sharing personal information and how fellow members might use it. It also provided an experience of Bowen's argument that when one focuses on oneself this automatically lowers anxiety and provides a space for objective reflection.

In the subsequent presentations each participant reflected on what thinking they had done since the previous presentation and what they had experimented with in terms of differentiating themselves within their families. The final session was a summation of each person's experiences of FoO and a discussion about the relevance of these efforts in terms of clinical work and managing anxiety in the workplace.

Following the trial the group members met informally on a number of occasions to reflect on the impacts and outcomes of the trial on themselves as clinicians, their work with clients and their functioning within the workplace.

Post-trial reflections

Given space restraints, and having already commented from our experience on some of the aspects raised by critics of FoO coaching, our reflections will focus on what we consider to be a fundamental area of contention as well as a key finding from our trial, namely the focus of FoO coaching on the therapist as an individual. As well as the ethical dilemmas it raises, the key concern raised in the literature is whether FoO coaching is not so much a tool that contributes directly to client care as it is individual therapy for the trainee or therapist's own benefit outside of their clinical duties. Deliberation therefore surrounds the question of whether it is appropriate for service providers, such as Redbank House, to spend clinical time and budget on a supervisory tool that benefits the therapist as an individual rather than as a clinician. Our comments on this debate, based on observations during and after our trial, are best grouped into four key aspects (see Figure 1) that we consider important to the ultimate goal of providing the best possible care of our clients.

Impacts of FoO on the therapists understanding of Bowen theory (see Fig 1a)

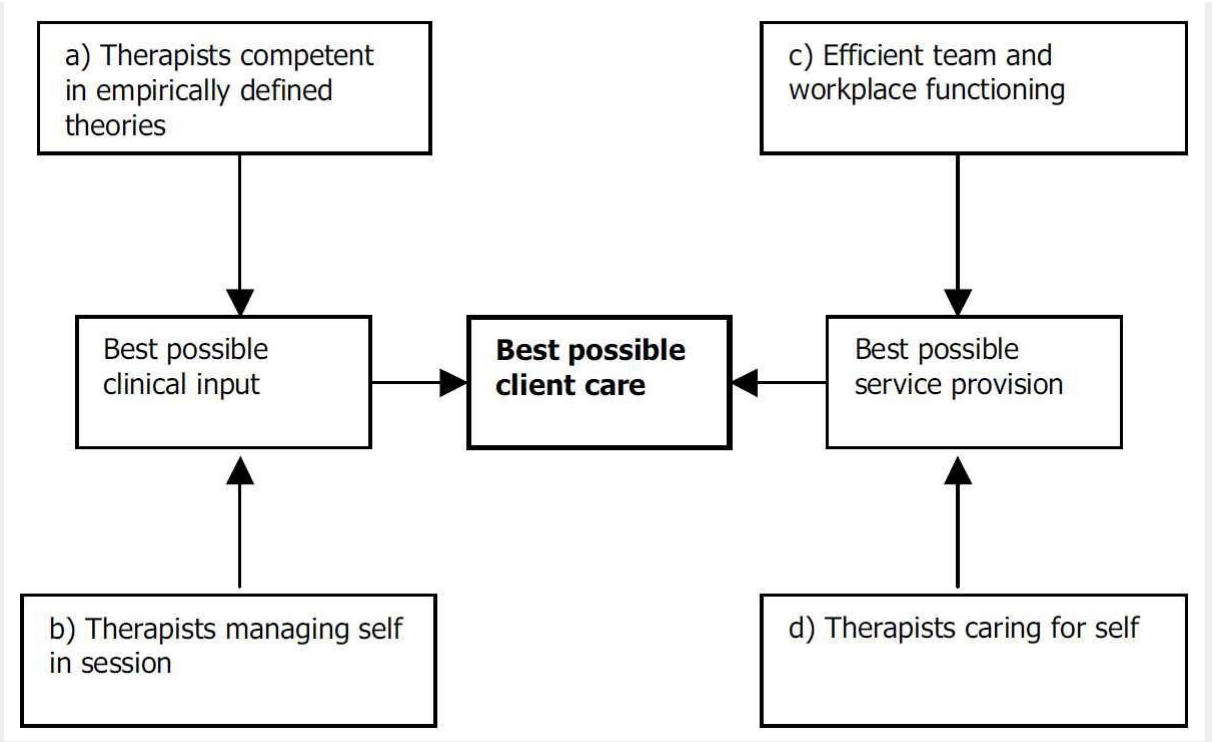

Figure 1 – Components of therapist and team functioning considered critical to the provision of best possible client care in a mental health care facility.

Hart reflects on the strive towards evidence-based practice when stating that, “one can imitate an outstanding supervisor, but without theory or a conceptual model one does not really understand the process of supervision” (as cited in Bernard & Goodyear, 1998, p.15). In response, our participants reported unanimously, regardless of experience level, that they found FoO coaching to be a key tool in terms of enhancing their theoretical understanding and mobilising the processes encapsulated in this model in a way that only an intense personal experience can. The result was a significantly enhanced confidence and competence in the model’s clinical application.

A further and unexpected outcome reported was the benefit of experiencing the exploration process from the client’s perspective which developed an empathy in terms of the immense challenges posed by trying to identify key trans-generational themes, the effort required to make changes to a current system, but also the ripple effect made by only small but potentially sustainable changes.

In addition, participants reported feeling more comfortable with the need for flexibility of pace and time at which these changes, and hence therapy, can occur in contrast to more familiar manualised and time-limited approaches.

Impacts of FoO on the therapist managing self in session (see Fig 1b)

Bowen’s “entire clinical method relies on the premise that any two people will resolve the difficulties between them best when defined in the presence of a third person who is actively related to both, and aligned with neither… none of that can be accomplished unless the clinician has achieved a level of self-definition that allows him or her to stay out of the amorphousness of the client family system” (Gillis-Donovan, 1991, p.12). Our team found that FoO coaching created the space and provided the means for us to work on isolating the individual set of processes that are likely to invite each of us into our client’s system, including themes that trigger our chronic anxiety, allegiances we are likely to make and roles we are likely to adopt, all of which are a result of patterns that have been transmitted down the generations of our respective families. These insights were then helpful and necessary in order to work towards increasing our own levels of differentiation. More importantly, FoO coaching provided an opportunity to apply these insights by learning to identify projection of these processes early on in our clinical sessions so as to make immediate changes to stay out of the client families’ systemic dilemmas.

By way of an example, one of our participant's investigations led to identification of a triangle in her family whereby she was aligned with her mother against a father who was distant. In one specific, and somewhat common example presenting to our service, was a client family whereby conflict in the marital relationship had been avoided by absorbing the daughter into a triangle, resulting in a fused mother-daughter alliance, leaving the father in an outsider position, and the daughter becoming increasingly symptomatic as focus on her served to avoid stress in the marriage. During FoO coaching the therapist realised that she had automatically adopted her FoO role and entered the client system by aligning with the client's mother which served only to replicate the processes that were playing out at the client's home and keeping the system stuck. On recognising this, the therapist worked at maintaining a neutral stance in session by providing equal space for the father to discuss his dilemmas and by inviting both the mother and daughter to speak for themselves instead of as a unit. This de-triangling where the father had an experience other that that of being in an outsider position and the mother and daughter could not resort to the comfort of their alliance, created a space in which all family members could experience a difference position and consider their contribution to the systemic issues raised. Ultimately, this process worked to free the daughter up to function for herself, with a consequent reduction in symptomology, as the anxiety focus stemming from the parents relationship was forced back to its true place within the parental dyad. This effort by the therapist to recognise an invitation within a client family to adopt a role that she would in her own family and work to counter this process, was observed to result in a number of clinical gains that were common to all team members efforts. Firstly, by taking an 'I' position the therapist modelled a stance of differentiation which is the desired outcome for each member of the client family. Secondly, the neutrality directed towards each family member by the therapist was observed to reduce the level of anxiety in the room, creating a calm environment that facilitated not only objective thinking, but thinking for and about oneself and one's role in the system. As Gills-Donovan (1991, p.14) states, "if one (therapist) is better defined and calmer, any family will know it and get calmer, which then allows them to step back and reflect on what is happening and potentially interrupt the automatic, reflexive cycles that are immobilizing them". Thirdly, the ability to differentiate from the client family's system freed the therapist up to focus energy and attention on driving the session according to the underlying theoretical principles, rather than being distracted by trying to manage the client family's emotional system.

Impacts of FoO on efficient team and workplace functioning (see Fig 1c)

Bowen (1978) maintained that differentiation of self principles applied to all relationships whether they were social relationships, relationships within the client family or work relationships and as a result he suggested that a problem in an organisation would resolve if at anytime one key member of that organisation could be responsible for self. In support, a major outcome of the FoO coaching experienced by our team was observed in terms of its impact on the functioning of our unit and the organisation as a whole. Following our trial, we observed how the same unique processes and patterns of reactivity that we had identified from our family of origin research were played out in the workplace when under stress or when confronted with differences of opinion. In response we attempted to foster a workplace environment where differences of opinion, which are inevitable given the multi-disciplinary nature and complexity of a health care facility, were dealt with by each person working on being a differentiated self. That is tolerating the tension created by differences without responding to our known reactivity triggers and taking responsibility for self while holding true to our individual convictions. Efforts to mobilise our FoO insights as colleagues as well as clinicians were observed to resolve issues faster, more effectively and with less impact on other team members, compared with how issues had been resolved previous to the FOO trial. Specifically, developing the ability to contain and resolve issues within the one-to-one relationship in which they arose resulted in anxiety being kept low and prevented it from spilling over into the wider team. This relieved other team members from becoming involved via invitations to align in some way and more senior staff from becoming mediators. It also prevented the potential for some team members to respond to stress by cutting-off which would lead to a maintenance of the anxiety and possibly low job satisfaction, as the stress trigger is not resolved. Consequently, stresses and differences were efficiently resolved so that resources could remain focused on issues of best client care. The ripple effect of these efforts was observed by the team to further impact on the wider organisation in that the ability for any one unit to hold a differentiated stance resulted in the same benefits during inter-unit and inter-department interactions.

Impacts of FoO on therapists caring for self (see Fig 1d)

Providing a specific space for clinicians to work on becoming more differentiated individuals within their own families, "provides an avenue for lessening tendencies to become over involved with one's clinical families, and it helps the family therapist avoid emotional "burn-out", a common occupational hazard for psychotherapists"

(Titleman, 1987, p.3). Considering all six members of our FoO supervision group described themselves as overfunctioners, we all observed an improvement in terms of energy levels when we ceased overfunctioning for our clients or team members in attempts to push for changes or, alternatively, cutting-off as a way of managing difficult situations or relationships. While causation is only hypothesised, this contrasted significantly towards feelings of burnout and low job satisfaction reported by a number of our team members the previous year and suggests that FoO coaching efforts were not only clinically beneficial but were experienced as self-preserving on an individual level. Bowen describes this result of the differentiation process as the ability to be in emotional contact with a difficult, emotionally charged problem and not feel compelled to preach about what others should do, not rush in to fix the problem and not pretend to be detached by emotionally insulating oneself" (Kerr & Bowen, 1988, p.108). Our team would go further to suggest that an effort by each team member to remain differentiated within the workplace, that is to remain connected and active but not overfunction for colleagues, further contributes to reducing burnout and increasing job satisfaction.

Finally, our team experienced FoO coaching as an incredibly validating and empowering process, in that it acknowledged therapists as human with unhelpful traits and states like any other and hence highlighted the importance of providing a means to learn to manage these so as to better function in work and life.

Limitations and potential future directions

While this article suggests that the inclusion of FoO coaching in the supervision of family therapists can enhance clinical, professional and personal functioning, it is acknowledged that we are only offering experiential validity to the literature and FoO is not an empirically tested premise. It is also acknowledges that from a methodological point of view we did not utilise the complete FoO coaching package recommended by Bowen, as we did not role-play how therapist FoO patterns played out in specific clinical examples and these were not formally presented or analysed due to time and session restrictions. Nevertheless, while we acknowledge that our FoO trial lacked some elements that would make it a more useful advisory for comparison, we still consider our experience of FoO training helpful for admission into the debate.

The next decade of supervision research will benefit by responding to Holloway and Neufeldt (1995) who ask, "What are the critical factors in supervision process that result in effective teaching of the therapist and effective treatment of the client". We suggest that supervision research should not neglect to consider FoO coaching which we hypothesise will be found to be a critical factor in establishing empirically valid models of family therapy supervision.

Conclusion

Saying that a therapist's personal development can be clearly delineated from their development as a clinician is to suggest that we are in some way immune to the interpersonal relationships that govern any individuals every day behaviour, and suggests that we as therapists can in some way simply separate ourselves from the very family systems that we preach govern any and every system of beings. Furthermore, it fails to acknowledge that our work consists of more than the mastery of a clinical skill, but rather a skill that exists within a complex system of multi-disciplinary team members working in an environment that functions on a number of parameters in its efforts to provide the level of client care we aim for. Surely, the provision of a space and means for one to become expert on one's own functioning and learn to "manage one's own madness" (Sinason, as cited in Young, 2003), such as that offered by FoO coaching, can only be beneficial use of an organisations time and budget, if our ultimate goal is to provide the most experienced and efficient clinicians, in an inspiring and functional work environment, that together can provide the best possible care of our clients.

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